

Wisconsin Department of Safety and Professional Services

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MONITORING

SELF REPORT

Complete this form and submit it to the Department Monitor at the address listed above.
It is recommended you keep a copy of each completed form for your files.

Name: _____ Due Date: _____
Last First Middle Month / Day / Year

Address: _____
Street City State Zip Code

Home Phone: (____) _____ Work Phone: (____) _____

Is this a new address or phone number? _____ Yes _____ No

TREATMENT

Current Therapist: _____
Last First Middle

Number of sessions required: _____ per _____

Are you in compliance with this requirement? _____ Yes _____ No

Dates of sessions attended and an explanation for missed sessions: _____

Has there been a change in your treatment program in the last quarter? _____ Yes _____ No

Have you and/or your Treater notified the Department Monitor of this change? _____ Yes _____ No

Describe your relapse prevention plan. _____

Discuss issues you are working on in treatment. _____

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What leisure activities have you participated in this quarter? _____

Please use this page to discuss your overall compliance with the Board Order (specifically including whether you have remained abstinent, if applicable) and any other information you would like to provide.

